MEDICAL BENEFIT SUMMARY

Administered by UnitedHealthcare/ Oxford

Visit www.osc.ct.gov/ctpartner **[click "provider lookup"]** to search the list of network providers.

IN NETWORK	CT Partnership Plan 2.0 w/ Health Enhancement Program
Medical Office Visit	$15 Co-pay
Specialist Office Visit	$15 Co-pay
Vision Exams (one per calendar year)	$15 Co-pay
Inpatient Hospital	$0 Co-pay
Outpatient Surgical	$0 Co-pay
Emergency Room	$35 Co-pay (waived if admitted)
Urgent Care	$15 Co-pay
Walk In	$15 Co-pay
Lab/ X-Ray High Cost Radiological & Diagnostic Tests	$0 Co-pay
Deductible	Individual: $350 Family: $350 each member ($1,400 maximum). Waived for HEP-compliant members.
Coinsurance	Not applicable
Max out of pocket	$2,000 individual / $4,000 family

PREVENTIVE SERVICES	CT Partnership Plan 2.0 w/ Health Enhancement Program
Primary Care (Adult and Child Wellness Exams)	$0 Co-pay
Gynecologist Wellness	$0 Co-pay
Mammogram	$0 Co-pay
Lifetime Maximum	Unlimited

PRESCRIPTION COVERAGE	MAINTENANCE DRUGS	NON-MAINTENANCE DRUGS	HEP CHRONIC CONDITION DRUGS
Generic	$5	$5	$0
Preferred/Listed Brand Name	$10	$20	$5
Non-Preferred/Non-Listed Brand Name	$25	$35	$12.50
Annual Maximum	Unlimited		
Max out of pocket	$4,600 individual / $9,200 family		

OUT OF NETWORK	CT Partnership Plan 2.0 w/ Health Enhancement Program
Annual Deductible	$300 individual/$900 family
Coinsurance	20% of allowable UCR charges
Max Out-of-Pocket	$2,300 individual / $4,900 family
Lifetime Maximum	Unlimited

ADDITIONAL MEDICAL BENEFIT INFORMATION

IN NETWORK	CT Partnership Plan 2.0 **w/ Health Enhancement Program**
Deductible	Not applicable*
Acupuncture (20 visits/year)	$15 Co-pay
Chiropractic	$0 Co-pay
Nutritional Counseling (3 visits/year)	$0 Co-pay
Physical/Occupational Therapy	$0 Co-pay
Durable Medical Equipment	$0 Co-pay
Routine Hearing Screening (as part of an exam)	$15 Co-pay

Visit www.osc.ct.gov/ctpartner **[click "provider lookup"]** to search the list of network providers.

UnitedHealthcare/Oxford Contact Information

Live, knowledgeable customer service representatives are available for current State of Connecticut Partnership 2.0 members toll-free at **800-385-9055** from 8am to 6pm EST, Monday through Friday.

If you prefer, you may also visit **http://partnershipstateofct.welcometouhc.com** to search for a participating physician or facility, to learn about your health plan, to find the status of claims, or obtain additional information about discount programs offered to State of Connecticut Partnership members.

UnitedHealth Allies: This health discount program helps you, and your family, save money on many health and wellness purchases not included in your standard health benefit plan.

DENTAL BENEFIT SUMMARY

Administered by Cigna

	Unlimited Maximum Plan	$750 Annual Maximum Plan	$1,000 Annual Maxiumum Plan	$1,500 Annual Maximum Plan	DHMO
	IN/OUT NETWORK	**IN/OUT NETWORK**	**IN/OUT NETWORK**	**IN/OUT NETWORK**	**IN/OUT NETWORK**
Annual Deductible	$0	$0	$25 indiv/$75 family	$0	$0
Annual Maximum	NONE	$750	$1,000	$1,500	NONE
Lifetime Orthodontia Max	N/A	N/A	$1,500	$1,500	covered
DEDUCTIBLE WAIVED					
Preventive	N/A	N/A	Yes	N/A	N/A
Basic	N/A	N/A	No	N/A	N/A
Major	N/A	N/A	No	N/A	N/A
PREVENTATIVE					
X-Ray	100%	100%	100%	100%	100%
Cleanings	100%	100%	100%	100%	100%
Oral Exam	100%	100%	100%	100%	100%
Flouride	80%	100%	80%	100%	100%
BASIC					
Fillings	80%	0%	80%	80%	covered
Endodontics	80%	0%	80%	80%	covered
Periodontics	80%/50%	0%	80%/50%	80%	covered
Simple Extractions	80%	100%	80%	80%	covered
Dentures (Repair Only)	80%	0%	80%	80%	covered
Bridges (Repair Only)	80%	0%	80%	80%	covered
MAJOR					
Crown	67%	0%	50%	67%	covered
Inlays	67%	0%	50%	67%	covered
Onlays	67%	0%	50%	67%	covered
Dentures	0%	0%	0%	67%	covered
Bridges	0%	0%	0%	67%	covered
Space Maintainers	67%	100%	50%	100%	covered
Oral Surgery	67%	0%	50%	67%	covered
ORTHODONTIA					
Braces (Adult & Child)	N/A	N/A	50%	50% Child Only	covered

VISION RIDER

Administered by Cigna

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Materials Copay	$0	N/A
Single Vision Lenses	Covered in Full	$40 Allowance
Bifocal Lenses	Covered in Full	$65 Allowance
Trifocal Lenses	Covered in Full	$75 Allowance
Lenticular Lenses	Covered in Full	$100 Allowance
Contact Lenses (Retail Allowance)		
Elective	$360 Allowance	$345 Allowance
Therapeutic	Covered in Full	$345 Allowance
Frame (Retail Allowance)	$175 Allowance	$126 Allowance

Frequency is 12 months for lenses, contact lenses, and frames.

In-Network Benefits Include:

One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)

Lens Options:

- Standard Polycarbonate: covered for under 18 years of age; min. 20% save, $40 out-of-pocket max. for adults
- Oversize lenses: covered under plan
- Rose Tints: #1 and #2 - covered under plan
- Solid Tints: min. 20% save, $15 out-of-pocket max. Gradient Tints: $20 out-of-pocket max.
- Standard photochromics: 20% save, $78 out-of-pocket max.
- Standard anti-reflective coating: min. 20% save, $45 out-of-pocket max. Standard scratch/ UV coating: min. 20% save, $17 out-of-pocket max.
- Progressive lenses: covered up to bifocal lens amount with 20% savings on the difference;
- $81 out-of-pocket max. for standard lens

One frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance.

One pair or a single purchase supply of contact lenses - in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lense professional services (including the fitting and evaluation), and contact lens materials.

Vision Network Savings Program:

- Minimum 20% savings on additional purchases of frames and/or lenses, including lens options, with a valid prescription; offered savings does not apply to contact lens materials. Check with your Cigna Vision Network Provider for details.

2016 HEP PREVENTIVE CARE REQUIREMENTS

Preventive Service	Birth – Age 1	Age 1-5	Age 6-17	Age 18 – 24	Age 25 – 29	Age 30 – 39	Age 40 – 49	Age 50+
Preventive Visits	At least 1 per year	At least 1 per year	Every 2 years	Every 3 years	Every 3 years	Every 3 years	Every 2 years	Every year
Vision Exam	N/A	N/A	N/A	Every 7 years	Every 7 years	Every 7 years	Every 4 years	50 -64 Every 3 years 65 and over Every 2 years
Dental Cleanings*	N/A	N/A	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year	At least 1 per year
Cholesterol Screening	N/A	N/A	N/A	Every 5 years starting at 20	Every 5 years	Every 3 years	Every 2 years	Every year
Cervical Cancer Screening (Pap Smear)	N/A	N/A	N/A	Every 3 years starting at 21	Every 3 years	Every 3 years	Every 3 years	Every 3 years
Colorectal Cancer Screening	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Colonoscopy every 10 years or Annual FIT/FOBT

These requirements meet compliance with the HEP Preventive Program as outlined in the SEBAC agreement.

As is currently the case under the State Health plan, any medical decisions will continue to be made by you and your physician

IMPORTANT CONTACT INFORMATION

Oxford - Medical	
Customer Service for Members	800-385-9055
Website Member Portal	http://partnershipstateofct.welcometouhc.com

Cigna - Dental & Vision	
Customer Service for Members	(800) 244-6224
Website Member Portal	www.cigna.com/sites/stateofct-partnership

CVS Caremark - Pharmacy	
Customer Service for Members	800-318-2572
Website Member Portal	www.cvscaremark.com